MEDI-CAL UPDATE Part 2 Billing and Policy www.medi-cal.ca.gov

Pharmacy

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Home Infusion Billing Workshop

New Blood Factor Billing Method for Pharmacy Providers Coming Soon

Effective for dates of service on or after July 1, 2006, pharmacy providers must bill Blood Factor and Anti-Hemophilia Factor products using National Drug Codes instead of billing "By Report." Providers can submit claims hard copy or electronically. However, providers who bill for California Children's Services (CCS)-only, CCS/Healthy Families, Genetically Handicapped Persons Program (GHPP)-only eligible recipients, or for Medi-Cal/CCS/GHPP-eligible recipients with a CCS or GHPP Legacy or a CCS *Service Authorization Request*, must continue to bill hard copy with the required authorization by the Children's Medical Services Branch.

All other provider types must continue to bill using the "By Report" methodology currently in place using the *HCFA 1500* claim form.

Medi-Cal will continue to reimburse providers the lesser of the manufacturer's Average Selling Price plus 20 percent or the provider's usual and customary charge.

Provider manual pages regarding this policy will be updated in a future *Medi-Cal Update*.

Universal Product Number Pilot Project for Medical Supply Billing

The following notice is in preparation for future changes related to medical supply billing. Please continue to bill for medical supplies according to existing policies until further notice.

It is anticipated that beginning January 1, 2008 billing requirements for medical supply claims will change significantly due to the Health Insurance Portability and Accountability Act (HIPAA), which mandates the use of HCPCS Level II codes on electronic claims. As a result, the California Department of Health Services (CDHS) plans to discontinue use of all interim medical supply codes and convert to HCPCS Level II. This change requires attachments on a majority of these claims.

To assist providers, CDHS received from the Centers for Medicare and Medicaid Services (CMS) an exception to the HIPAA standards, which allows for the use of the Universal Product Number (UPN) or bar code as part of a two-year pilot project. This project allows participating providers to submit the UPN on electronic and paper claims for the following four product categories:

1. Urinary catheters and bags
2. Incontinence supplies
3. Ostomy care products
4. Wound care products

Please see **UPN**, *page 2*

UPN *(continued)*

CDHS will actively seek volunteers to participate in the UPN pilot project. When billing for products in the four categories, some of the advantages of participation include:

- On-line real-time claims processing, which allows for immediate claim status notification
- No requirement to submit claim attachments
- Improved speed and accuracy of claim payments

Non-participating providers will be required to bill HCPCS Level II codes on all medical supply claims. The majority of these claims will continue to require attachments, and on-line real time claims processing will not be available.

CDHS will conduct a survey beginning in June 2006 to assess the level of provider interest in the UPN pilot project. Additional details about the project and information about responding to the survey will be on the Medi-Cal Web site and in future *Medi-Cal Updates*.

Public Comment Forum Available Through July 31, 2006
Providers can e-mail questions and comments regarding the UPN pilot project and medical supply HIPAA compliance efforts to CDHS through the Medi-Cal Public Comment Forum. The "Medi-Cal Comment Forum" page is located in the "HIPAA Update" area of the Medi-Cal Web site (**www.medi-cal.ca.gov**). Providers should click the "HIPAA" link on the home page and then the "Medi-Cal Comment Forum" link. The forum will be available April 7 through July 31, 2006. Questions will be collected and summarized into a FAQ and posted on the Medi-Cal Web site this summer.

New Lower Limb Prostheses Benefit

Effective for dates of service on or after May 1, 2006, HCPCS code L5611 (addition to lower extremity, endoskeletal system, above knee – knee disarticulation, 4-bar linkage, with friction swing phase control) is a Medi-Cal benefit.

Lower limb prostheses (HCPCS codes L5610 – L5617) are reimbursable only when a referring physician has documented the medical necessity for these types of appliances. Code L5611 is appropriate only for recipients with a medical necessity for "swing phase control," and is restricted to once per three-year period. The prosthetist must submit a *Treatment Authorization Request* (TAR) that documents the recipient's functional needs, including the recipient's:

- Past history, including prior prosthetic use, if applicable;
- Current condition, including status of the residual limb and the nature of other medical problems;
- Ability to reach or maintain a defined functional state within a defined and reasonable period of time; and
- Motivation to ambulate.

A patient's functional level must be "1" or higher to qualify for this benefit. Any individual whose functional level is "0" is not a candidate for this type of prosthesis and Medi-Cal coverage will be denied.

The updated information is reflected on manual replacement pages ortho 4 and ortho cd2 5 (Part 2).

Exceptions to Submitting CIFs

Providers are reminded not to submit *Claims Inquiry Forms* (CIFs) for the following Remittance Advice Details (RAD) code messages, unless information on the CIF specifically addresses the denial reason. For example, if the denial was 002, but an error is found in the recipient ID on the original claim, this would be an appropriate CIF, with a changed recipient ID. However, if providers wish to challenge the determination, a CIF will result in the same denial. A review by a person in the appeals unit is the only way of resolving denials if the claim has a unique circumstance needing human intervention.

Code	Message
0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
0010	This service is a duplicate of a previously paid claim.
0072	This service is included in another procedure code billed on the same date of service.
0095	This service is not payable due to a procedure, or procedure and modifier, previously reimbursed.
0314	Recipient not eligible for the month of service billed.
0326	Another procedure with a primary surgeon modifier has been previously paid for the same recipient on the same date of service.

The updated information is reflected on manual replacement page cif co 2 (Part 2).

CCS/GHPP SAR Exceptions Update

Effective for dates of service on or after April 1, 2006, California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) providers need a separate Service Authorization Request (SAR) for the following drugs, factors and nutritional products:

- Anti-Inhibitors (J7198)
- Factor VIIa Recombinant (Q0187)
- Minerals/Protein Replacements/Supplements
- Sildenafil
- Tadalafil
- Vardenafil
- Von Willebrand Factors (Q2022)

In addition, effective for dates of service on or after April 1, 2006, Factor VIIa Recombinant should be billed using HCPCS code Q0187. HCPCS code Z5230 will no longer be an active code.

This updated information is reflected on manual replacement page cal child sar 6 (Part 2).

Presumptive Eligibility Program 2006 Poverty Level Income Guidelines

The 2006 Federal Poverty Income Guidelines are effective April 1, 2006 through March 31, 2007. The guidelines are used to determine eligibility for Presumptive Eligibility (PE) program services for pregnant women. Applicants are eligible if their gross family incomes are at or below the revised poverty levels shown in the following table. The applicant's unborn child is counted as a member of the family; therefore, the guidelines begin with two persons (the mother and her unborn child). For specific PE questions, call the Telephone Service Center (TSC) at 1-800-541-5555.

FEDERAL POVERTY INCOME GUIDELINES
200 Percent of Poverty by Family Size

Number of Persons	Gross Monthly Income	Gross Annual Income
2	$ 2,200	$ 26,400
3	$ 2,767	$ 33,200
4	$ 3,334	$ 40,000
5	$ 3,900	$ 46,800
6	$ 4,467	$ 53,600
7	$ 5,034	$ 60,400
8	$ 5,600	$ 67,200
9	$ 6,167	$ 74,000
10	$ 6,734	$ 80,800
For each additional person, add	$ 567	$ 6,800

This updated information is reflected on manual replacement page <u>*presum 6*</u> *(Part 2).*

Family PACT 2006 Poverty Level Income Guidelines

The 2006 Federal Poverty Income Guidelines are effective for the Family PACT (Planning, Access, Care and Treatment) Program for dates of service on or after May 1, 2006. The guidelines are used to determine financial eligibility for the program. Applicants are eligible if their gross family incomes are at or below the revised poverty levels shown in the following table.

FEDERAL POVERTY INCOME GUIDELINES
200 Percent of Poverty by Family Size

Number of Persons	Monthly Income	Annual Income
1	$ 1,634	$ 19,600
2	$ 2,200	$ 26,400
3	$ 2,767	$ 33,200
4	$ 3,334	$ 40,000
5	$ 3,900	$ 46,800
6	$ 4,467	$ 53,600
7	$ 5,034	$ 60,400
8	$ 5,600	$ 67,200
9	$ 6,167	$ 74,000
10	$ 6,734	$ 80,800
For each additional person, add	$ 567	$ 6,800

Revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual pages will be issued in a future mailing to Family PACT providers. For more information about Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m. Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

CHDP 2006 Poverty Level Income Guidelines

The 2006 Federal Poverty Income Guidelines are effective April 1, 2006 through March 31, 2007. The guidelines are used to determine eligibility for the Child Health and Disability Prevention (CHDP) program. Applicants are eligible if their gross family incomes are at or below the revised poverty levels shown in the following chart.

For additional CHDP information, call the Telephone Service Center (TSC) at 1-800-541-5555.

FEDERAL POVERTY INCOME GUIDELINES
200 Percent of Poverty by Family Size

Number of Persons	Gross Monthly Income	Gross Annual Income
1	$ 1,634	$ 19,600
2	$ 2,200	$ 26,400
3	$ 2,767	$ 33,200
4	$ 3,334	$ 40,000
5	$ 3,900	$ 46,800
6	$ 4,467	$ 53,600
7	$ 5,034	$ 60,400
8	$ 5,600	$ 67,200
9	$ 6,167	$ 74,000
10	$ 6,734	$ 80,800
For each additional person, add	$ 567	$ 6,800

Federal Upper Limit Terminology Change

All references to the term “Federal Allowable Cost” and its acronym “FAC” in the Medi-Cal manuals have been changed to “Federal Upper Limit” and “FUL.” This is a terminology change only, and has no affect on billing and policy.

The updated information is reflected on manual replacement pages claim pay 1 (Part 1), drugs cdl p3 2 thru 4 (Part 2), drugs maic ful 1 thru 46 (Part 2) and reimbursement 1 and 4 (Part 2).

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Remove and replace:	*Contents for Pharmacy Billing and Policy* iii/iv *
Remove and replace:	cal child sar 5/6
Remove: Insert:	cif co 1 thru 10 cif co 1 thru 11
Remove and replace:	drugs cdl p3 1 thru 4
Remove	drugs maic fac 1 thru 46
Insert after the end of the *Drugs: Contract Drugs List Part 8 – Step Therapy* section:	*Drugs: MAIC and FUL List* 1 thru 46
Remove and replace:	ortho 3 thru 6 ortho cd2 3 thru 8 presum 5/6 reimbursement 1 thru 4 tax 7/8 *

* Pages updated due to ongoing provider manual revisions.